PRINTED: 05/17/2010
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN8901	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PICKETT CARE AND REHABILITATION CENTE	129 HILLCREST DRIVE BYRDSTOWN, TN 38549

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 832	1200-8-6-.08(2) Building Standards (2) The condition of the physical plant and the overall nursing home environment must be developed and maintained in such a manner that the safety and well-being of residents are assured. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to comply with the state building standards. The findings included: During the facility tour on 5/16/10 the following deficiencies were noted and verified by the Director of Maintenance. At 10:25 Observation of the outside area revealed a large hole in the wall. Tennessee Department of Health (TDOH). 1200-8-6-.08(2)	N 832	**N 832** **Corrective Actions for residents affected:** Facility maintenance staff complete needed repairs on old vent opening on 5/21/10. Fire rated dry wall was fit into the opening with brick laid to finish. **Identification of residents with potential to be affected:** On 5/17/09 the Maintenance Supervisor checked building exterior walls with no other concerns discovered. **Measures to prevent reoccurrence:** Exterior walls will be included in monthly facility maintenance checks by Administrator/Maintenance Supervisor. Any noted issues shall be addressed for corrections/repairs immediately. Also, following all new construction, exterior walls will be check for integrity. **Monitoring of Corrective Action:** As a means of Quality Assurance the Maintenance Supervisor will report any concerns to the monthly Safety Committee.	5/21/10

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE Administrator (X6) DATE 5/25/10